western
Rethink Insurance

GROUP PERSONAL ACCIDENT

Claim Form

INSURED

Name of insured
Policy number
Contact person
Contact phone number
Contact email address

INCIDENT

Estimate
Date and time of incident
Date and time discovered
Date and time reported
Place of loss

Injured on duty? -Please Select-
Death? -Please Select-
Is this incident covered under any other policy of insurance? -Please Select-

POLICE

Place where reported
Date of reporting
Case number (if reported)

EMPLOYEE

Name
Contact phone number
Contact email address
Address
Occupation

TEMPORARY / PERMANENT DISABLEMENT

Expected dates off-duty
Expected percentage of permanent disablement

Please tick which of the following documents are attached

Doctor's certificate
Confirmation of percentage disablement by doctor
Letter of appointment
First & Final Medical report
Original medical accounts and medical aid statements
Police plan and report on scene of accident

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IN CASE OF DEATH

Beneficiaries under the policy

Name

Policy number

Contact number

Address

Documents attached (please tick if attached)

Post Mortem report

Inquest report

Letter of executorship

DECLARATION

I / we declare that to the best of my / our knowledge the above statements are true. I acknowledge that the information set out above is provided freely so that Western may process my claim and give effect to the terms and conditions contained in the policy wording. I herewith give my consent that Western may use this information, my personal information on record and additional information obtained from other sources in order to determine whether to accept or reject my claim and take all necessary steps ancillary thereto to give effect hereto.
I understand that I may be liable for output VAT in terms of the Value-Added Tax Act, 10 of 2000.

Insured's signature	Capacity	Date

Cape Town
T 021 914 0290
F 021 914 0293
E info@westnat.com

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